NHS
Kent Community Health
NHS Foundation Trust

Health Visiting Strategy
2022-2025

we care

Foreword

Kent's Health Visiting Service delivers over 200,000 contacts every year, in homes and community venues across the county, from a children's centre in Margate to a front room in Meopham.

Health visitors lead the Healthy Child Programme and we have a highly skilled and diverse workforce able to work collaboratively with families, communities and partners to address health inequalities.

Our colleagues work with families before birth, in the early days, and up until their children start school. Having the best start in life during these early years has a lifelong impact on health and wellbeing. We hear from our workforce and families how the support the Health Visiting Service gives makes a huge difference to them during this exciting and challenging time. Some families tell us they wouldn't have known how they would have got through without the intensive support they received or from others, how just a quick conversation and reassuring word helped them successfully navigate a challenge.

We have worked with our families, colleagues and stakeholders to create this strategy for the next three years, in line with the timescales of our current partnership arrangement with Kent County Council. We believe it allows us to develop our services based on evidence and in partnerships that will help us improve the lives of children, families and communities, at the right pace to make sure that by 2025, the Health Visiting Service is in the very best place possible to meet the changing needs of our families.

We could not be prouder to lead this service; our staff are outstanding, working with families through kindness and professionalism in challenging times.

Karen Whitehouse and Rhona Clover

Head of Operational Services Health Visiting

"Health visitors are an essential part of the country's support structure for young children and their parents – especially those who are struggling to cope."

Anne Longfield,
Children's Commissioner for England (2019)[1]

[1] Institute of Health Visiting (2019) Written evidence submitted by Institute of Health Visiting (DEL0249). Available at: https://committees.parliament.uk/writtenevidence/4597/html/#_ftnref3 (Accessed 25 May 2022).

KCC foreword

Setting the foundations for health and wellbeing during pregnancy and in the early years of childhood are crucial to help every child have the best start in life as possible.

New parents need to be supported as they make the transition to parenthood and have access to support when they need it most. This will help their child to grow, develop, and thrive, ready to learn and ready for school. Kent takes in a large geographic area with differing population and needs across the county such as increasing complex health and social needs, widening health inequalities, workforce challenges, and new families arriving in the county. There are around 89,500 nought to four-year-olds in Kent.

The Health Visiting Service supports families and leads on the Government's Healthy Child Programme, launched 11 years ago and updated in 2021. **No Child Left Behind** clearly highlights the necessity to focus on reducing vulnerabilities, addressing inequalities and providing a safeguarding role in partnership with the local authority, together with a comprehensive approach to identifying and addressing the needs of children and families.

The care delivered by the Health Visiting Service in collaboration with midwives, school nurse teams and integrated children's services will be an essential part in the recovery from the pandemic, supporting families and communities through indirect impacts and 'hidden harms' especially in deprived communities and among the most vulnerable.

This document provides a sound basis on which to further evolve the Health Visiting Services practice.

Dr Anjan Ghosh

Director of Public Health, Kent County Council.

Setting the foundations for health and wellbeing during pregnancy and in the early years of childhood are crucial to help every child have the best start in life as possible.

Dr Anjan Ghosh,
Director of Public Health,
Kent County Council

Health Visiting in Kent

Health visiting is often traced back to 1862 in the North-West of England, where a group of women worked to increase knowledge about the public health issues of the day, including comfort and cleanliness, focusing on practical education and help for women and children. In Kent today, the topics may have changed but the focus remains on improving the health and wellbeing of families. The profession of health visiting and Health Visiting Services, have gone from strength to strength since its origins.

Health Visitors make a key contribution to ensuring that every child receives the best start for life. Disadvantage in the early years can extend across generations and lead to costlier later intervention. A universal public health approach focusing on prevention and early intervention contributes to making sure children meet their full potential and live as healthy a life as possible.

The Health Visiting Service lead the nought-to-five element of the healthy child programme, an evidence-based programme of public health interventions to support families to achieve the best level of health and wellbeing that they can. The programme is universal in reach whilst being personalised in response. Health visitors are experts in identifying health needs early, providing early intervention where appropriate and working with partners in our local system to make sure the needs are met and escalation is prevented. This approach makes sure the service has a key role in reducing health inequalities.

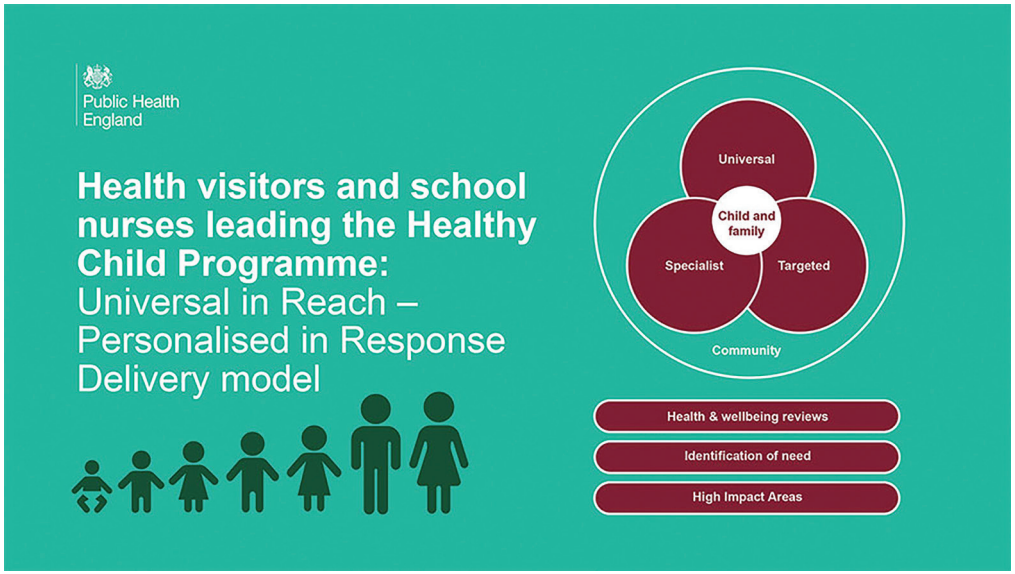
The current model of delivery in Kent mirrors the levels of support model in the national healthy child programme. This is based on a model of proportionate universalism, recognising that all families need some support, but some need more. This approach enables to service to contribute to a reduction in health inequalities.

"Health visitors … are the first port of call for new parents and they provide fundamental support, advice and early interventions. These services provide critical early warnings around deprivation, substance misuse and safeguarding."

Best Start for Life (2021)[2].

Overview of the healthy child programme

[2]HM Government (2021). The Best Start for Life. A vision for the 1,001 Critical Days. The Early Years Healthy Development Review Report. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973112/The_best_start_for_life_a_vision_for_the_1_001_critical_days.pdf Accessed (10 January 2022).



Public Health England (2021)[2]

The levels of support are:

- Community – all families
- Universal - all families
- Targeted - families who require some extra support
- Specialist - families who require multiagency support for complex needs, including safeguarding families[2].

Kent is a large county, with more than 17,000 babies born every year. The service has hundreds of thousands of contacts with families each year, requiring the different levels of support.

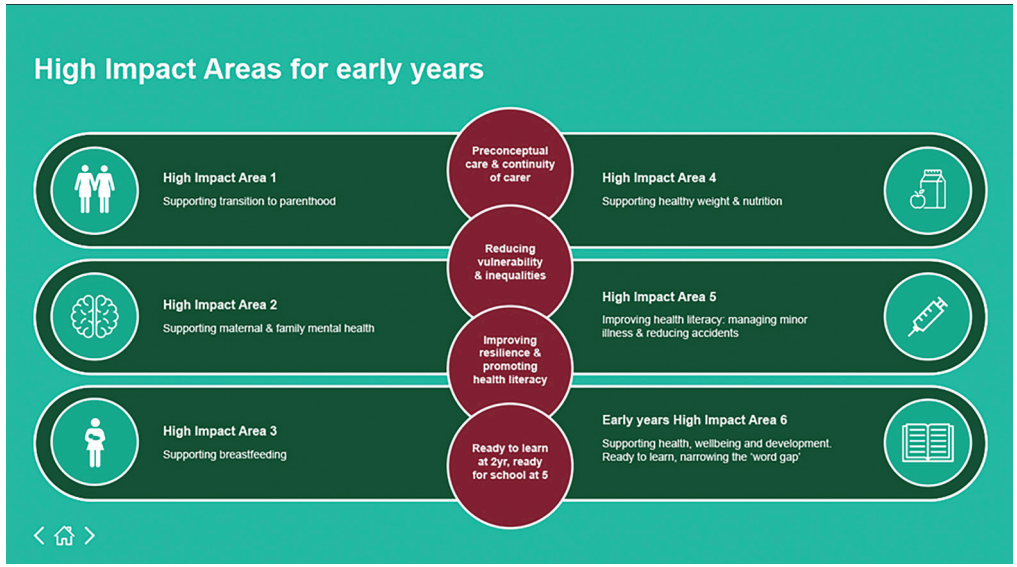
A key element of the programme are five **universal health and wellbeing reviews**, these are:

- Antenatal health promoting review
- New baby review
- Six to eight-week review
- Nine to twelve months developmental review
- Two to two-and-a-half-year developmental review.

At these key assessment points, at open access opportunities (including a telephone advice line and clinics) or on referral from partners, the service takes a strengths-based approach to engage with families and provide universal health promotion, identify need and provide early intervention around the **six high impact areas**. Health visitors will also signpost and refer families to other services who can meet their needs, acting for some families as care navigators.

The teams take a place-based approach, rooted in the communities they work in and building strong relationships with local partners to meet population-specific needs.

The Six High Impact Areas



Public Health England (2021)[2]

Why do we need a strategy now?

Our model is led by health visitors, nurses and midwives who have undergone specialist public health training. They work with a team of practitioners; community public health nurses and senior public health assistants. The support for families with the most intense needs is primarily carried out by health visitors and family partnership programme leads. The community public health nurses and senior public health assistants deliver the health and wellbeing reviews to families to universal families and also support targeted and specialist families delivering the health and wellbeing reviews and additional support related to the six high impact areas.

Over the last 10 years Health Visiting Services have gone through enormous change and challenge. This has included changes to commissioning arrangements, the introduction of the health visiting implementation plan, mandated health and wellbeing reviews and the recent modernisation of the Healthy Child Programme. Over the last two years the service has been operating through a pandemic, meaning that our services were delivered in different ways. Families have faced extraordinary challenges through the pandemic and are now experiencing rising costs of living and widening inequality. As a consequence, families are presenting with increased complexity, which has put a pressure on the system of providers who work together to meet their needs. It is likely that Kent's population will continue to change, with population movement and growth.

New national guidance to support the delivery of service in the early years has been published over the last two years and there is more to come. Key documents have included The Best Start for Life (2021)[3], the refreshed delivery model for **Health Visiting and School Nursing (2021)**[2] and the **Family Hubs: Local Transformation Fund guidance and Framework (2021)**[3]. These are setting out a clear policy framework for the early years, where the Health Visiting Service is firmly placed in a wider system of collaboration between partners to deliver care for babies, children and families. Health visiting, perinatal mental health and infant feeding are three of the six core services to be delivered as part of a collaborative family hub offer. National guidance on the modernised healthy child programme is also due imminently. Family hub development is being led by KCC Integrated Children's Services and we are working closely with KCC to develop the Kent approach. As this work is still in the early stages the strategy is focused on actions to be taken within the Health Visiting Service which are aligned to the national and local direction.

We are committed to working with our partners to deliver joint priorities, as we know that the needs of families in the early years can only be met if we work collaboratively as one seamless system of providers and commissioners. Working together also makes us more resilient in our delivery. As new governance frameworks are implemented, the workstreams related to the strategy will be linked and move forward as part of local work to develop of family hubs and in line with the new national healthy child programme.

This strategy aims to build a framework for the development of the service over the next three years, to ensure that **by 2025 we have in place a sustainable Health Visiting Service; meeting the varied needs of families in Kent then and for the future and supporting our staff to thrive**. This strategy has been developed with Kent County Council who we have a legal partnership with and other system partners.

[3]Department for Education (2021). The Family Hubs: Local Transformation Fund Guidance. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1030243/FH_Transformation_ Fund_-_LA_Application_Guide.pdf Accessed (10 January 2022)

Strategy Development

The strategy presented here has been informed by a number of key activities during the autumn and winter of 2021. They included:

- A programme of staff engagement; including large engagement events attended by over 200 people and over 20 individual interviews with staff from across the service.
- A review of the service datasets.
- An analysis of the combined patient engagement activity that has been undertaken over the last three years.
- Engagement with key stakeholders from across the system, including Clinical Commissioning Group commissioners, Kent County Council, Kent County Council (KCC) Public Health Commissioners, KCC Public Health and KCC integrated Children's Services.
- A series of senior management and leadership workshops
- A review of a draft of the nought to four years health needs assessment completed by KCC Public Health Team and recent national policy documents, including; The best start in life: a vision for the 1001 critical days[3] and the Health visiting and School Nursing Service Delivery Model (2021).[2]

This strategy does not include a key aspect of the service, specialist breastfeeding support. This element of service will be considered in a separate multiagency review.

The needs of families with children aged nought to five in Kent

The Kent County Council public health team have carried out a health needs assessment for families with children under five years of age, which is unpublished at the time of this strategy's development. This has looked at the needs of children of this age, and the services in Kent which aim to meet their needs. The key findings from the review are in the box below. These findings are in line with the findings of our own review. We aim through the changes proposed in this document to contribute to the system's response to the recommendations made in the needs assessment.

Key findings of Kent's nought-to-four needs assessment:

- There is **inadequate workforce capacity** within the system to meet the needs of the population. Demand exceeds capacity for care and support to provide universal and targeted provision, which is exacerbated by the change in thresholds for referrals and service responsibilities.
- The needs presented by families are becoming **more complex**. The impact of the wider determinants of health and social needs are presenting through health service use.
- The **distribution of services** in Kent does not match the picture of demand or need.
- The **expected levels of development of nought to fours** are not being met and there is an increase in the perceived and/or actual demand on specialist services, exacerbated by the COVID-19 pandemic.
- The process for **identifying and understanding the emotional and mental health and wellbeing needs of children under two is not known**. Furthermore, helping parents to develop and maintain good mental health is key to supporting their child's wellbeing.
- The social gradient in health is being accentuated in Kent. There is a **changing picture of need** and indicative measures of poor future health status are being observed, such as rising obesity levels in children.
- There is a **need for a system-wide approach** to preventing poor health outcomes, ensuring provision and levels of support are flexible and responsive to meet needs. This includes improved data sharing across services and multi-agency partners.

Strategic aims

There are a number of underpinning principles of the strategy, that run through all of the strategic aims:

- The service is **universal** in reach but **personalised** in response
- Each team belongs to its community and works as part of a **local system**
- There is a **trained and supported workforce** available to deliver the service and meet the needs of the population
- To respect and enhance the health visiting profession as a **specialist public health role**
- Practitioners have **autonomy** to make assessments and decisions in partnership with families and other professionals about care
- **Continuity** of care should be delivered wherever possible
- **Safeguarding** children and families is central to all our work
- The service works in **partnership** with families when delivering support and developing the offer
- The service has a clear role in **reducing inequalities**
- Changes to services are **developed and implemented in partnership** with the health visiting workforce.

Strategic aims

We have six strategic aims:

1. Delivering a sustainable model of care to meet our population's health and wellbeing needs
2. Providing a strengthened early intervention offer across the six high impact areas
3. Delivering a strengths-based approach through the family partnership programme
4. Ensuring our services are accessible to all our communities
5. Working effectively with our partners to provide seamless care and improve outcomes
6. Using technology, data and information to support service delivery and improvement

Strategic aim one: Delivering a sustainable model of care to meet our population's health and wellbeing needs

While developing this strategy we found that as we have moved out of the acute phase of the pandemic, there are significant challenges to our delivery model. These are as a result of increased complexity of need in our clients and reduced numbers of staff, particularly health visitors. This has resulted in health visitors having a concentration of safeguarding cases, changing the balance of their role and consequently putting further pressure on the wider service. Some of these impacts have been felt more acutely by some district teams, where the reductions in staff numbers have been greater and has led to a variation in what is delivered across the county and by which staffing group. This has meant some staff have reported feeling like they had not met all of a family's needs, particularly when they are complex, but not complex enough to need safeguarding support. This pressure has been exacerbated where the health visitors have also been required to deliver universal health and wellbeing reviews. We also found that staffing role groups were working separately from one another, carrying out prescribed jobs according to their role, leaving some feeling they have to support their families alone. In some areas we have not been able to deliver support around the six high impact areas that we would have wanted to.

In addition, the external and internal pressures on the workforce meant that continuity of care was not being maintained across the health and wellbeing reviews. This could impact on the outcomes for families, but also resulted in some of our workforce feeling they were not able to build effective relationships with families.

Even with this pressure, our staff have continued to deliver health and wellbeing reviews to a high proportion of our families and we have engaged fully with the statutory safeguarding procedures.

Every Health Visiting Service in the country is having difficulties maintaining their workforce and we are no different. We have had to look to alternative ways to both ensure that we maintain our universal offer whilst giving the more intensive support to those families who need it and effectively supporting our staff.

In response to the challenges we face we will implement two main changes to our model of health visiting in Kent as part of the strategy implementation.

Health Visitors will continue to lead and oversee delivery of all health visiting care.

Introduction of early years public health assistants

Early years public health assistants will be introduced across the county. This will have a number of benefits. These include introducing a new entry point into the health visiting workforce, helping progression through the service if desired. Our early years public health assistants will focus on delivering the health and wellbeing developmental reviews at nine to twelve months and two to two-and-a-half years for universal families only. This will consequently release our senior public health assistants who have delivered these reviews up to this point, to focus on delivering offers of support across the six high impact areas for families with targeted and specialist needs. This will help senior public health assistants to use all their knowledge, skills and abilities to work in partnership with families to meet their health and wellbeing goals.

Re-aligning levels of support and the workforce to provide holistic support for families with longer term complex needs

To help our staff meet the needs of our families, we will have four levels of support, compared to the three outlined above.

We will split the specialist level into two, to differentiate those families who are on a statutory safeguarding caseload and those that have complex long-term needs, including those with multiple vulnerabilities and disabilities. This will allow us to more effectively understand and meet the needs of these groups. This will also allow us to align our caseloads with the Kent Support Levels guidance, and facilitate more effective joint working with our partners in integrated children's services.

Guidance will be developed to support the differentiation of caseloads.

In the new model, the role of health visitors to support families with safeguarding and complex needs will be enhanced, protected and supported by other members of the team. **The health visiting workforce is limited and those specialist skills will be dedicated to supporting families with a specialist level of need.** Health visitors will lead and oversee the care for this caseload. They will provide assessments and offers of care when they are required and work within multiagency teams (within the safeguarding structures where required) to support the co-ordination of care. **The health visitor will delegate work to community public health nurses and senior public health assistants to meet their caseload's health and wellbeing needs**, including offers of care under the six high impact areas and additional support for families to meet their goals. The health visitor will provide leadership and supervision of care.

District caseloads and teams will be divided to have sub-district geographical focus to enhance the community role of the service. These will be aligned to meaningful communities allowing the teams to work more effectively within them with partners. Each district will have a hub which will host central functions including administration and professional liaison. This work will happen alongside our Reimagining Teams Programme.

Health visitors will have opportunities to carry out work with the universal caseload, however, they will not be routinely delivering universal health and wellbeing reviews.

The new model for families associated to the different levels of need are:

1. Universal Support Caseload - universal level of need

The majority of families will sit within this group and all need some support from the Health Visiting Service. This will be delivered through the health and wellbeing reviews to provide robust strength-based assessments for families to identify needs and support and to deliver key health messages. Before birth, they will receive information about the service and sources of support and be offered an antenatal contact if the family are first-time parents, or the opportunity to request an antenatal contact if they are second-time parents. We will continue to aim to provide all families an antenatal contact, when workforce pressures allow. Ensuring continuity of care is a priority for the service. Wherever possible families will have their new birth and six-to-eight-week review delivered face-to-face by the same practitioner at home, and their nine-to-twelve-month and two-to-two-and-a-half-year review delivered by the same practitioner in a clinic setting.

Families will have access to the service at any time through a health visiting advice line and open-access drop-in child health clinics and drop-in breastfeeding groups. High quality online and digital resources will be available or signposted from the health visiting website and apps. Online parenting sessions will also be available on key topics such as introducing solids and toilet training. Digital inclusion will be considered within this offer and other methods of providing information will be available.

If the needs of the families in this level change at any time, they will receive the support they require and move to a higher level of need.

2. Targeted Support Caseload - Families with who are low risk and have short-term additional needs

Some families will have needs that can be met in the short term within the Health Visiting Service or by signposting/referral to other services. These families will have access to all the support available to universal families but will temporarily become part of a targeted caseload whilst they have these needs met or are referred on. All families on this caseload who are identified antenatally in partnership with the midwifery team will receive an antenatal contact. This includes the delivery of an offer of care individually or in groups for topics related the six high impact areas. These will be mainly delivered by community public health nurses and senior public health assistants. The specialist infant feeding service will also provide intervention to this caseload. Families will re-join the universal caseload after the short-term needs have been met or the referral made. Families will be empowered to contact the service if they have any further questions or issues.

If the needs of the families in this level change at any time, they will receive the support they require and move to the appropriate level of need.

Bookable child health clinics will operate for families on a targeted caseload to help families be seen in line with their care plan and by their named practitioner, promoting continuity of support whenever possible.

3. Complex specialist caseload and safeguarding specialist caseload - Families with longer term complex needs receiving multiagency support and co-ordination

A small number of families will be in these groups. Each family on these caseloads will have a named health visitor who will lead their assessment and care within small geographically based areas. The health visitor will lead and oversee the work of the community public health nurses and senior public health assistants, who will also deliver support and interventions including the nine to twelve month and two to two-and-a-half-year development reviews where appropriate to this caseload. Where the family are receiving safeguarding support and on the safeguarding specialist caseload, the health visitor will attend the required meetings and coordinate care with partners. The care provided by the team will utilise the family partnership strengths-based approach.

Care for families will include the five health and wellbeing reviews, additional contacts to meet health and wellbeing goals, and support and interventions linked to the six high impact areas. This approach will allow the service to deliver additional contacts at the right time by the right member of the team. The families on this caseload will have access to all elements of the universal open access provision. The team will work closely with the other services providing care to families to ensure they receive coordinated support. Additional contacts may be specifically linked to safeguarding plans.

Bookable child health clinics will operate for families on the specialist caseload to help families to be seen and offered follow-up appointments with the Health Visiting Service in line with their care plan and with their named worker for continuity. Families will be able to step down from these caseloads when their goals have been met or their safeguarding status has changed.

The model of care is summarised in the below table.

	Universal	Targeted	Specialist — complex	Specialist — safeguarding
Antenatal Health and Wellbeing Review (HWR) Delivered virtually or face-to-face in clinic or at home	First time parents CPHN contact Second time parents CPHN contact delivered on request	CPHN contact	Health visitor contact	Health visitor contact
New birth HWR Delivered at home	CPHN contact	CPHN contact	Health visitor contact	Health visitor contact
Six to eight-week HWR Delivered in clinic or at home	CPHN contact	CPHN contact	Health visitor contact	Health visitor contact
Nine to 12-month HWR Delivered in clinic or at home	EYPHA contact	SPHA contact	SPHA contact	SPHA contact
Two to two-and-a-half HWR Delivered in clinic or at home	EYPHA contact	SPHA contact	SPHA contact	SPHA contact

Health visiting advice line	✓	✓	✓	✓
Open access child health clinics	✓	✓	✓	✓
Bookable access child health clinics		✓	✓	✓
Breastfeeding groups	✓	✓	✓	✓
Online offer	✓	✓	✓	✓
Parenting programmes (online, virtual and face-to-face)	✓	✓	✓	✓
Specialist Infant Feeding Service		✓	✓	✓
Offers of support for six high impact areas		✓	✓	✓
Health visitor-led support working in partnership with families, health visiting team members and external partners			✓	✓

CPHN – community public health nurse

EYPHA – early years public health assistant

SPHA – senior public health assistant

The new model will be implemented over two years, in partnership with our workforce and in the context of family hubs development. It will be trialled in selected areas, working in partnership with the local team to work through cycles of change to identify what works best for families. A continuing programme of staff engagement will help ongoing engagement throughout the implementation of the new model. Clear communication channels will also be developed to make sure colleagues are aware of proposals and changes at every stage. This will form an ongoing internal communication and staff engagement programme for the future.

Key to the development and implementation of the new model will be a programme of client engagement and co-production.

An important element of the implementation will be a workforce development programme. This will support the transition of colleagues into the new model. We also need to make sure we have a stable workforce across all the staff groups so care can be delivered and colleagues do not face pressures due to changes in staffing numbers. There will be dedicated workstreams to support sustainable recruitment, retention, development and career progression.

To support the implementation of the new model we will look at how efficiencies can be made for practitioners in terms of administration, meeting structures and travel.

The new model will be supported by the review and consultation of the business and administration structures. This will recognise the key role they play in making sure families are supported efficiently and effectively.

Strategic aim two: Providing a strengthened early intervention offer across the six high impact areas

Our work has highlighted that there are elements of the six high impact areas, where the health visiting offers of support could be improved and where there are gaps in the wider system. As part of the strategy implementation we will strengthen these offers, which will be delivered at greater scale through the dedicated senior public health assistants and partners. We will also work with our partners who provide specialist services so that pathways of care are joined up. The key areas for priority development are:

Parenting programmes – Work is underway to d**evelop virtual and face to face groups to support families across a wide range of parenting topics across the nought to four age range**. This work will continue within the service and in partnership with integrated children's services at the local authority, parents and care givers.

Healthy weight – Work is underway to **develop a pathway of support through the service to prevent children reaching or are already at an unhealthy weight**. This work will continue to be implemented and evaluated.

Perinatal and infant mental health and speech, language and communication needs – These areas have been recognised in national and local policy as areas for improvement. The service has recently recruited dedicated programme managers for each area **to review the current offer, develop proposals for future arrangements within the service and to assess how it can be integrated with the rest of the system offer**. The options appraisal for future delivery will include working in partnership with other professionals and organisations, and the implementation of the early language identification measure and intervention.

SEND and neurodevelopmental needs – The Kent system recognises that increased support should be available for families and children with potential neurodevelopmental issues. **The service will link with the current system initiatives to identify and support families.**

Strategic aim three: Supporting a strengths-based approach through the family partnership programme

The family partnership programme was implemented in the Health Visiting Service in 2019. This programme was developed in partnership with the Centre for Child and Parent Support at the South London and Maudsley (SLAM) NHS Foundation Trust. The family partnership model uses a strengths-based process to build a partnership between the client and professional to support the client in overcoming challenges, building resilience and meeting their goals.

There are two parts to the programme. The first part of the programme is to train all client-facing colleagues in the use of the model to underpin the relationships with their clients, using the tools available. This has been supported by a family partnership assessment tool becoming the service's key family needs assessment tool and using the partnership approach to underpin the service's early interventions. **The service will continue to roll out the training and make sure that the tools are used**. We will also refresh the family partnership supervision programme in the health Visiting teams led by the family partnership leads to ensure consistent engagement and support for using the model. This will continue to be monitored routinely in partnership with SLAM.

A key element of the family partnership approach is **contracting and building a strong relationship with families**, which helps everyone to understand what the other needs for the relationship to progress. This will be emphasised throughout all the contacts the service has, to ensure that our families have clear expectations of what the service can offer and understand how and when they engage. This includes attending booked appointments, particularly the health and wellbeing reviews.

The second part is an intensive home visiting programme led by dedicated health visitors up to the age of one, guided by the family partnership framework and developed for Kent by the Health Visiting Service and the Centre for Child and Parent Support. This is the first time that this intensive intervention has been implemented and it has been specifically designed for Kent. The home visiting programme works with families who have one or more identified vulnerabilities. There are one or more leads in each of the 12 districts who also support the implementation of the programme within main Health Visiting Service. The programme has undergone a period of continued evaluation and changes have been made to alter elements of its delivery. The caseloads held by the nurses have been found to be more complex than initially expected, a recent change has increased the capacity of the programme and reduced the size of the caseload to reflect this. The team has received outstanding feedback from its clients, and has very low levels of disengagement. It is now time to further understand the benefits the programme confers to these families. **The increased capacity will be implemented and an external evaluation will be commissioned.**

Strategic aim four: Accessible services for all our communities

As a universal service, health visiting has to be easily accessible for all. In addition, as the service works with the most vulnerable in our communities where travel or engagement may be more challenging the service needs to reach out to these families to maximise engagement and reduce inequalities.

In recent years the service has continued to develop and improve our communications with families and to develop online free-to-access supportive resources for families, to empower them to make changes. This has included the refresh of the Born to Move App, online parenting groups and an online free to access parenting programme. However, we know that sometimes our families may not be completely aware of the breadth of our offer or have expectations for us to deliver things that are not part of our early intervention remit.

We will now work to develop a communications plan which makes sure our offer is easily-understood and accessible, supported by the face-to-face contacts that people have with the service.

We will continue to improve our online offer, by improving our website and digital provisions whilst ensuring our that our clients know about it.

We will use social media platforms to drive engagement and awareness of the service and the support available, co-produced with our service users. The impact of digital poverty will be considered in this work.

The accessibility of our service relies on our administrative systems working as effectively and efficiently as possible. We know some of our systems require modernising. We have had feedback from service users about the inflexibility of the arrangement of assigned appointments at the nine to twelve months and two to two-and-a-half year health and wellbeing developmental reviews. We also don't consistently use text messaging or email to reach people. **We will review our IT solutions to support our administrative processes, including online booking and the use of automated text and email to provide reminders and information. We will also work to make sure staff have the equipment and Wifi accessibility they need to effectively do their job.**

Throughout the pandemic there have been challenges in delivering in the community due to changes in the availability of accessible venues. In the short term the service is using the available estate to deliver our clinics. Over the next year, partners will review and reopen their venues and it will become clearer what is available to us in the longer term, particularly with the development of family hubs by Kent County Council.

During COVID the district-based phone advice lines have seen a huge increase in users and are operated differently across the districts. The time is split on these lines between supporting professionals and clients. Parents have reported the huge value of the advice line to get the support they need. However, colleagues have told us of the large numbers of calls that are received in some districts and the requirement to staff them from the local team. As a result, more adequately staffed districts are supporting the advice line in less well staffed areas. **We will review the provision of district-based advice lines and professional liaison to assess their role, efficiency and effectiveness, supported by the recent introduction of an 8x8 online system to more effectively filter calls.**

There are opportunities to provide clients with choice in the way support is provided, to help ease of contact and responsiveness. The service will consider additional methods of open access support, including webchat and texting.

The service operates Monday to Friday, 9am to 5pm. However, we know from clients and staff that an offer outside of these hours may have greater reach for some families and may provide more flexibility for our staff. This would contribute to work to reduce the number of appointments where clients don't attend and increase uptake in the development reviews. **Our operating hours will be reviewed as part of the proposed new model in partnership with staff and clients.**

The numbers of appointments not attended by families are greater than we would like, families are not receiving the support they could benefit from and the services have appointment slots which are not used. We think some of the initiatives above will support a reduction in these occurrences. **We will carry out an in-depth piece of work to look at who does not attend their appointments and the reasons for this.**

Strategic aim five: Working effectively with our partners to provide joined up care and improve outcomes

Kent is a big place, which means we have many different communities with different needs and different networks of services delivering to them. With staffing challenges, district-based delivery and reduced clinics, the service has reported feeling remote from its communities and experiencing reduced engagement with their community partners. Some staff also fed back that they were less aware of the supportive services in the local area, limiting their ability to signpost. This has reduced our ability to fully deliver the community offer of the healthy child programme. This is at least partly attributable to the impact of COVID on statutory and voluntary sector organisations.

The wider health and care system is currently reorganising to work at a place-based level, recognising that there can be more impact for our clients if we work together in distinct communities. The service will also work with the emerging systems to be part of the opportunities available to deliver at a place-based level, including, but not limited to, the proposed GP-led Children's Multi-Disciplinary Teams in Swale and east Kent and the reducing inequalities in maternity workstream. A key relationship is with our maternity partners; the service will continue to engage in the programme of work with both the local maternity and neonatal system and our acute trusts.

The changes outlined in this programme are in line with the national emphasis of the **Start for Life** offer and modernisation of the healthy child programme. Part of the programme is the national drive to develop **family hubs**; virtual and physical spaces for all families to receive multiagency support. The development of these are being led by Kent County Council (KCC) Integrated Children's Services, with the Health Visiting Service and infant feeding support being two of the six core services which are required to be provided within them. **The service will continue to fully engage with the development of hubs and their required offer, and the start for life and healthy child programme policy requirements as they are published.**

Through the pandemic and changing service delivery there have been changing perceptions of what each service should deliver to families. In response, we have committed to working together to develop a memorandum of understanding with KCC Integrated Children's Services to make sure each service understands the responsibilities of the other, and what our service will deliver. This also aims to develop links across teams and embed good practice. As part of this, the service will develop a safeguarding dashboard to provide assurance around safeguarding.

Over the last two years the service has developed an offer in partnership with KCC public health commissioners, the Education People and early years providers to provide an integrated review at two (IR2). This process allows health visiting and early years providers to work together to assess and support children and families where a targeted need has been identified. **In partnership with KCC, the service is now carrying out an 'IR2: a year on' review, to see whether it is achieving the impact expected and assess if the current process is efficient.** The recommendations from this will be implemented.

Strategic aim six: Using technology, data and information to support service delivery and improvement

The Health Visiting Service is rich in information. Every contact is recorded by the professional delivering contact, providing a significant degree of detail which can be used by team to build a care plan with the family.

However, we have heard from colleagues that record-keeping has become overwhelming and often takes longer than the contact itself. This is in part due to the increasing complexity of cases, which require additional record-keeping, but also due to the change in clinical record-keeping system and the processes currently required. There are some supportive elements built into the clinical record-keeping system, including the use of templates, but it is not known how widely or effectively these are used. Record-keeping is potentially putting further strain on our already stretched resources.

A workstream will be set up to review the process of record-keeping to transform the way in which activity is documented in the future.

As well as the records held by the service, the Personal Child Health Record (known as the red book) is a handheld record for each child given to families at birth. It is intended to be used by all services who have contact with the child in the first five years and enables them to see other professional entries. It also contains reference guides and advice. As part of the NHS long-term plan there is an ambition to develop an e-red book which will be implemented country wide. **We will follow the national implementation plans for the e-red book.**

The information recorded by clinicians allows managers to understand what is being delivered, to who and what has been achieved, helping us to assess whether the needs of our population are being met. Information provided regarding the mandated health and wellbeing reviews and associated assessments, breastfeeding and the intensive family partnership programme is of a high quality and there is good assurance around the support provided.

However, information related to other elements of service delivery including the advice line, child health clinics, any contacts other that than the mandated health and wellbeing reviews are not recorded in a way that can be used to inform service change. Another key omission in our data recording is recording improvement outcomes following a piece of targeted work with a family.

Measuring this would mean we could objectively measure whether the support provided resulted in a difference to the family, and whether additional support was required. We also do not routinely record body mass index (BMI) at our two to two-and-a-half-year review, which could inform planning. In addition, only just under half of our clients have an ethnic group reported. This means we cannot tailor our services to meet specific needs and contribute to a reduction in inequalities.

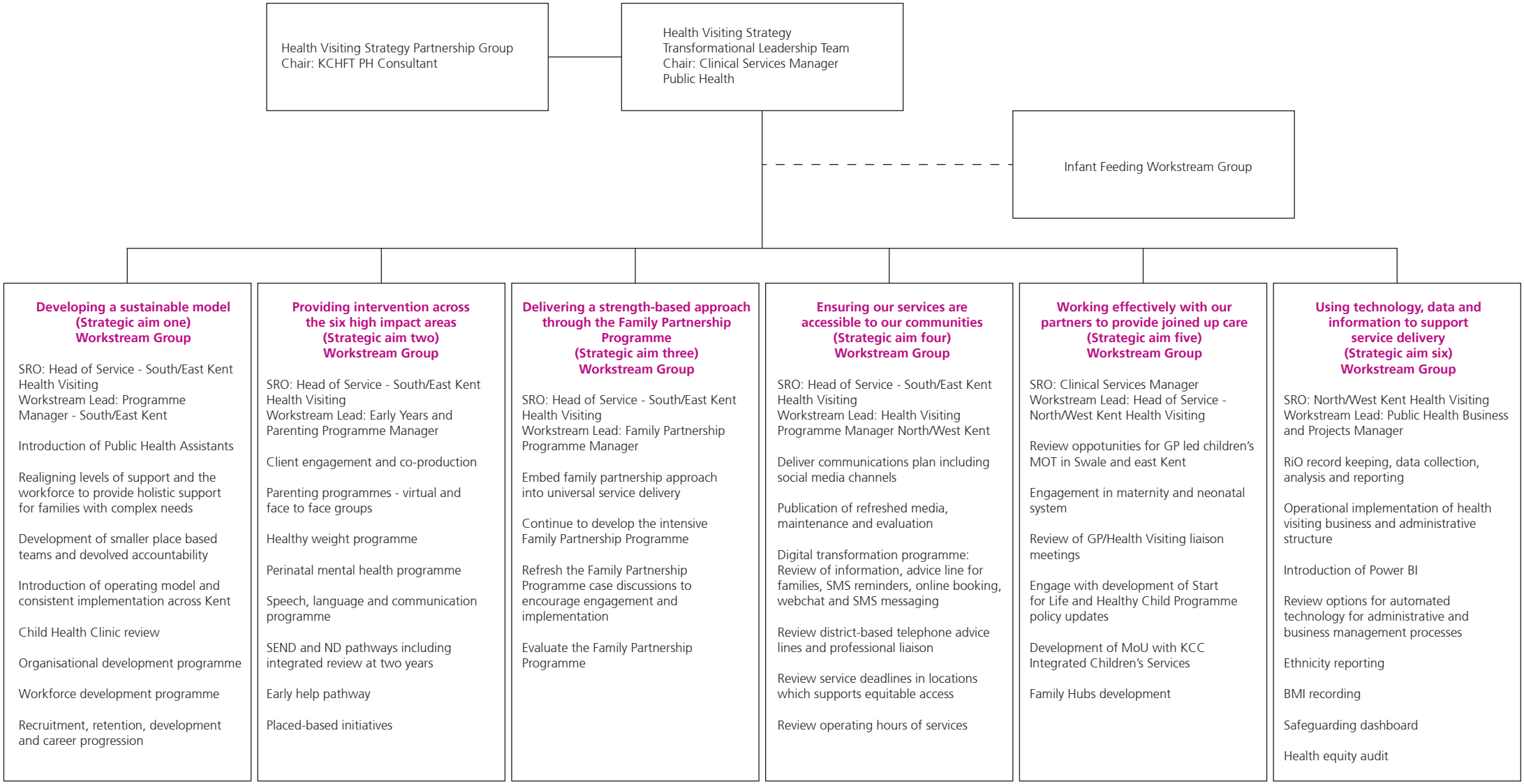
A task and finish group will be set up to improve the information recording and implement recommendations to make sure the service can understand the need for diverse delivery, the outcomes achieved and to monitor equity. This will include looking at robotic technology for administrative and business management processes to extract data from the multiple data sources health visiting receives. We will also support implementation of the Trust initiative to increase the reporting of ethnic group and other protected characteristics. Recording BMI at the two to two-and-a-half year review will become a mandated field. Finally, we will start work on consistently monitoring equity of provision, and complete a health equity audit, to ensure that the service is consistently contributing to the system wide work to reduce health inequalities.

Governance arrangements

This strategy document presents the broad initiatives and tasks we think are necessary to make sure by 2025 we have a sustainable Health Visiting Service, meeting the needs of the families of Kent and enabling our colleagues to thrive. Further work will be carried out by a number of workstreams, whose work will be underpinned by our underlying principles; to develop more detailed action plans and timescales to deliver what we have outlined above. These workstreams will include staff representatives from across the workforce. This work will be overseen by a health visiting internal operational oversight group supported by a strategic partnership group with our partners. The latter will make sure we continue to work in close collaboration with our system colleagues.

Our plans will only succeed if they are co-produced with our colleagues and clients. Co-production groups will work alongside or as part of the workstreams to ensure that the detailed development and implementation plans will work in practice and achieve the outcomes they set out to.

The structure of the groups that will make sure this strategy is developed, and the associated leads are presented in the below diagram. Some strategic aims have been merged to reflect operational responsibilities and overlap and the strategic breastfeeding group has been included.



The Health Visiting Strategy is underpinned with principles of engagement with our colleagues and families.

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